DOCUMENTATION

STATEMENT OF PURPOSE:

Student and staff health information is documented according to recommended nursing principles of documentation.

AUTHORIZATION/LEGAL REFERENCE:

- 18 V.S.A. Chapter 21 § 1124 - Access to Records
- 26 V.S.A. Chapter 28 § 1572(2) - Nurse Practice Act
- Secretary of Health & Human Services letter referencing FERPA and HIPAA relationship, September 1, 2004
- Vermont Department of Education Memorandum on Retention of Immunization Records, October 15, 2002

REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Document subjective and objective data, nursing assessment, interventions and plans in the student's health record or staff record.
2. Use the recommended principles of nursing documentation. (See attachment)
3. Maintain individual health records (See Confidentiality section) which may include:
    - Health assessments
    - School exams or screening; psychological reports according to school policy
    - Specific procedures and documentation of administering medication
    - Record of injuries and illnesses
    - Reports of abuse
    - Individual health plans
    - Release of information
    - 504 plan
    - Correspondence with other agencies
    - Documentation of training of delegated procedures
4. Maintain other documentation related to school health services
    - Accident reports
    - Medical incident reports
    - Annual immunization reports
    - Annual Department of Education screening reports
    - Staff delegation
    - Staff records
    - Emergency information
    - Supervision of staff
    - Reports of abuse
    - Correspondence with other agencies/health care providers
5. Follow Vermont policy and procedures for education records. (see attachment)

RESOURCES:

- HIPPA and Schools, School Health Alert, Nashville, TN, Special supplement, October 2003.
- National Association of School Nurses - www.nasn.org
- Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, p.311, Sunrise River Press, 2001

SAMPLE POLICIES, PROCEDURES AND FORMS:

- Nurses Principles of Documentation
- Errors in Documentation
- Reportable incidents
- Length of Time to Hold Records

Nursing Principles of Documentation

Nursing documentation should be accurate, objective, concise, thorough, timely, and well organized.

1. All entries should be legible and written in ink.
2. Computerized records must be secure and password protected.
3. The date and exact time should be included with each entry.
4. Documentation should include any nursing action taken in response to a student's problem.
5. Assessment data should include significant findings, both positive and negative.
6. All records, progress notes, individualized health care plans, and flow charts should be kept current.
7. Documentation should include only essential information; precise measurements, correct spelling and standard abbreviations should be used.
8. School nursing documentation should be based on nursing classification and include uniform data sets.
9. The frequency of documentation should be consistent over time and based on district policy, nursing protocols and the acuity of the student's health status.
10. Standardized health care plans increase efficiency of documentation and are acceptable to use so long as they are adapted to the individual needs of each student.
11. Student symptoms, concerns, and health maintenance questions (subjective data) should be documented in the student's own words.
12. Only facts (objective data) relevant to the student's care and clinical nursing judgments based on such facts should be recorded; personal judgments and opinions of the nurse should be omitted. For example, 'the students is breathing normally' is an opinion, whereas the notation 'respirations 20/min.; no retractions, rales or wheezing" provides objective data.'

(Reference: Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001)

Errors in Documentation

1. References to district problems, including staffing shortages, should never be included in student records.
2. Terms suggestive of an error should not be used, for example, “accidentally” or “by mistake”; state only the facts of what occurred.
3. When an error is made, one single line should be drawn through the error; the word “error” and the nurse’s signatures should be written directly above it. The correct entry should then follow. Words should never be erased or scratched or whited out.
4. When an entry is made in the wrong student’s record, the entry should be marked “mistake in entry,” and a line drawn through the mistaken entry, as above.
5. Late entries should be avoided. When necessary, a late entry may be added, but in the correct date and time sequence. (For example, write today’s date and time when entering a note related to care provided yesterday afternoon and mark it “late entry”.

Reportable Incidents

Reportable incidents that result in injury or potential injury should be documented. These include but are not limited to:

1. Injury requiring or probably requiring a physician’s or dentist’s care;
2. Injury referred by the nurse for medical evaluation;
3. Injury requiring major first aid;
4. Injury which has the potential for litigation; and
5. Failure to administer prescribed medication within the appropriate timeframe, in the correct dosage, or to the correct student.

Actions to be taken

1. Incident/Accident reports or medication error reports are completed as soon as possible within 24 hours of the occurrence;
2. Parents are notified;
3. Administration is notified immediately or in a timely manner;
4. Documentation in the student log reflects the facts of the incident and steps taken to rectify the situation;
5. Follow-up is completed and documented within 24-48 hours as needed; and
6. Copies of the report are filed in the Principal’s and/or Health Office, separate from the student’s record and intended for internal use/analysis.

Reference: Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001

Length of Time to Hold Records

Health records are treated like any other student record under federal and state laws. In Vermont, academic records including health records are held at least five years after a student leaves the school.

Reference: Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001